1201. C-7.25.1. Does the contractor's assistance with development of a comprehensive improvement plan involve any commitment of resources related to the plan?

RESPONSE: As stated, a minimum of one FTE is required. If the Regional Director requires additional assistance or resources in order to achieve the objects of the plan, that will be negotiated with the Contractor.

1202. L-14.f.(1)(a). The second to last sentence of this paragraph, as amended by amendment 0004, states that, "omission of standards for any proposed activity may result in unfavorable evaluation." We have the following questions:

a. Is it the Government's intent that offerors only include in the written technical proposal those standards that exceed the Government minimum?

RESPONSE: No. Where the offeror agrees to a Government standard, it need not repeat the Government standard. Where an offeror proposes to exceed a Government standard, the offeror must state the standard. In addition, an offeror must propose performance standards for which the Government has no standards.

b. Is it the Government's intent that offerors only include in the written technical proposal those standards that exceed the Government minimum and those standards related to a requirement for which the Government has not identified a standard?

RESPONSE: See above.

c. Is it the Government's intent that omission of any standard related to a requirement for which the Government has not identified a standard may result in an unfavorable evaluation?

RESPONSE: Yes

d. Is the Government's intent that any omission of any standard related to any requirement, regardless of whether the Government has or has not identified a standard, may result in an unfavorable evaluation?

RESPONSE: Please see our response to question 1202a.

1203. In Section L of Amendment 4 of the RFP, the Government clarified that L-4 and L-5 past performance documents with signatures within 60 days prior to the initial proposal submission date of 1 November 2002 would be acceptable. This encompasses documents with signatures back to 2 September 2002. The first RFP, however, came out on 1 August 2002. Thus, bidders could likely have obtained signatures during the month of August 2002. We would appreciate the Government making this requirement 60 days prior to the initial submission of the Past Performance Volume of 2 October 2002 so that rework would not need to take place. Please let us know, as soon as possible, if this would be acceptable.

RESPONSE: We will update this section to state: "The signature must be current – dated no earlier than August 2, 2002."

1204. Section L.14.f.2.i in part this statement reads 'The offeror shall provide copies of final reports and/or findings issued to the prime contractor and any first tier

subcontractor by any local, state or federal governing or regulatory/licensing body during the time period from two years prior to the submission of the past performance information.' Given Amendment #4 and the date change for submissions, can the government clarify the date we are to use so as to determine the correct time period for report submission.

RESPONSE: The date is two years prior to the submission date of the past performance information which is, with Amendment 4, January 15, 2003, the same date as the technical and business proposals are due.

1205. In your response to question #1080, regarding location of MTFs, you state: "These facilities are included on the maps posted on the web site." The map for the North Region does not list the following MTFs: 1. BMC NAS Brunswick, Brunswick, ME (DMIS ID 0299) 2. Dunham Army Health Clinic, Carlisle Barracks, PA (DMIS ID 0352) 3. Kirk Army Health Clinic, Aberdeen Proving Ground, MD (DMIS ID 0308)
The latest zip code data you provided for Prime Non-catchment areas indicates that TRICARE Prime is indeed provided in areas around each of these MTFs. Should these three MTFs be listed on the maps you posted on the web site?

RESPONSE: Yes

1206. The latest zip code data you provided for Prime Non-catchment areas in Region 1 indicates that TRICARE Prime is not offered in areas around the following BRAC sites: 1. Loring AFB 2. Plattsburgh AFB 3. Griffiss AFB 4. Indiantown Gap Does the government require contractors to provide TRICARE Prime in the areas listed above?

RESPONSE: Yes. See the answer to Question 1179 concerning the Prime Non-catchment data

1207. Amendment 4, attachment L - 8, Government Provided Data - South Contract, total reported Resource Sharing expenditures:

Region 4 annualized expenditures appear to be overstated by over 200%.
Is the expenditure total annual or life of the contract?
Do the expenditures include direct contracts the government has issued? Do the expenditures include non-TRICARE eligibles. Do the expenditures include External Resource Sharing? Resource Sharing HCSR data values are consistently approximately 50% less than the values included in attachment L-8 Do the Attachment L-8 values take into consideration valid expenditures incurred that would not be reflected in a HCSR (i.e., support and ancillary staff, marginal costs, equipment costs, sub-contractor overhead costs)? Do the Attachment L-8 values take into consideration External Resource Sharing expenditures that would be reflected in a network HCSR, which should be excluded from Resource Sharing HCSRs? The Gross Savings to Cost ratio for Region 6 appears overstated based on historical trends toward less than projected inpatient savings, due to budgetary restructuring toward delivering care in outpatient clinics.
Is the expenditure total annual or life of the contract?
Do the expenditures include direct contracts the government has issued? Do the expenditures include non-TRICARE eligibles? Do the expenditures include External Resource Sharing? Based on bullets 1 & 2, are attachment L-8 values reported based on consistent standards, (i.e., fee-for-service or salary provider incurred expenditures, marginal costs, equipment, and direct administrative costs

(credentialing, workload, etc.), reported to the government separate from HCSRs)? External Resource Sharing expenditures should be excluded. These assumptions are important to prevent an offeror from overstating the adjustment for current Resource Sharing contractor expenditures that will be incurred in option period 1thru Direct Care dollars instead .

RESPONSE: The L-8 expenditures reflect an annual value, not a value over the life of the contract. The L-8 expenditures do not include direct contracts. The L-8 expenditures do not include external resource sharing. The L-8 expenditures do include resource sharing expenditures not reported on HCSRs, as well as those expenditures that are reported on HCSRs. As stated in previous responses, the Government does not believe that the HCSR data includes all resource sharing costs. Therefore, the offeror's statement that the L-8 expenditures are overstated in comparison to HCSR-reported resource sharing is not a valid comparison.

1208. Section L.14.(o)(1) Health Care Prices. Offerors are to assume that an amount equivalent to current Resource Sharing expenditures, in the aggregate, shall be provided by the DoD to the direct care system.

What will be the effective date and for what incurred period will the Resource Sharing expenditures be based? Will the direct care system funding be allocated to the MTFs in option period 1 based on the specific Resource Sharing expenditures for initiatives in their facilities. Will MTFs within the same Region be allocated funding different from current expenditures? Will the government allocate direct care system funding to Regions based on assumptions other than existing expenditures at a particular point in time? Will Regions receive funding in amounts more or less than current expenditures?

RESPONSE: The transfer by DoD to the direct care system will occur prior to the start of health care delivery allowing each MTF to have the resources in place for the transition to the T-Nex contracts. The amounts transferred by DoD to the direct care system, for each former region, would reflect the Exhibit L-8 amounts trended for inflation. For a given region, the transfer will occur at the Service level, and each of the three Services will determine how to distribute its funding to its MTFs in the region.

1209. Section L.14.(o)(1), Health Care Prices. As for new Resource Sharing opportunities not done under current contracts, neither offerors nor the Government shall assume any Resource Sharing savings in purchased care during option period I.

Government provided data does not include MTF clinical capacity or staffing profile information typically provided in previous solicitations. For purposes of developing an adequate basis for offering new Resource Sharing opportunities that will augment direct care capacity, profile information may be obtained directly from the MTFs via phone to each facility. Will the government authorize the offerors access to clinical capacity and staffing profile information thru phone calls to the MTFs or thru specific web sites?

RESPONSE: Offerors are welcome to access each MTF’s web site and review listings of the services available, and if presented, the staff listings. Offerors are not authorized to phone MTF staff.

1210. RFP Section L.14.e.(1)(a)[2] requires a demonstration of how a provider network will be developed for the Naval Clinic, Millington, TN. In your response to question #1080, regarding location of MTFs, you state: "These facilities are included on the maps posted on the web site." The Naval Clinic, Millington, TN is not listed on the maps you posted on the web site. Can you verify that the Naval Clinic, Millington, TN is a Prime Service Area?

RESPONSE: The clinic at Millington, TN (Naval Support Activity – Mid- South) is a Prime area.

1211. Your answer to question #633 indicates that new contractors must continue to offer TRICARE Prime in non-catchment areas where current contractors offer this program without being directed to do so by the government. According to information available through the Internet, the current contractor for Region 1 has TRICARE Service Centers and a significant provider network available in and around Philadelphia and Pittsburgh. However, according to the latest zip code data provided by the government for Prime Non-catchment areas in Region 1, Prime is not offered in these cities. Does the government require contractors to offer TRICARE Prime in and around Philadelphia and Pittsburgh?

RESPONSE: Question 633 refers to beneficiaries who reside outside of a TRICARE Prime service area being allowed to enroll in Prime if the beneficiary waives the access standards. As for offering Prime in the current non-catchment Prime areas not required by this contract (e.g., Pittsburgh – Philadelphia is a BRAC site which requires Prime), the offeror should review RFP Amendment 4, Section M-6 and make its own determination where to offer additional Prime sites. In addition, we will be issuing an update to the non-catchment Prime area data; see the answer to Question 1179.

1212. RFP Section L.12.e. states: "Documents such as annual reports, previously printed materials, graphics or any other documents that cannot be submitted in electronic form are exempt." To submit Reports and Findings, as required in the Past Performance information (L-14) in an electronic format, they can be scanned as pictures and pasted into a Word document. However, some reports and findings average 1,000+ pages and when pasted into Word will create a document size in excess of 300 megabytes. These electronic files could be difficult to open, print and peruse; which may impede the government's review of the information.

Please confirm that Section L.14.f.(2)(i) – Reports and Findings – fall within the Section L.12.e. exemption, allowing us to provide hard copies only?

RESPONSE: No. There is no exemption. Section L.12.e. will be updated in a future amendment to eliminate the submission of any hard copy files.

1213. What is the ETA for the Marketing and Education Contract Solicitation?

RESPONSE: In Amendment 4, the RFP and the TRICARE Operations Manual was changed to reflect the fact that the Government will be responsible for developing and providing marketing and education materials vs. a contractor.

1214. Can a contractor propose using tools that cover the same material as the "Take Care of Yourself" manual?

RESPONSE: We are unclear as to the use of the term "tools" but the requirement for the contractor to provide a "Take Care of Yourself" manual to Prime households was eliminated in Amendment 4.

1215. What is the Government's current contract mandating use of the "Take Care of Yourself" manual?

RESPONSE: The current Managed Care Support contracts have varying requirements. Some contracts have no requirement for a self-help book; others direct that a self-help book be furnished; and others name the book.

1216. Q&A 242 reads as follows:

"QUESTION: C.7.4. - Does the requirement to comply with TRICARE policy and regulation regarding review and approval of mental health services apply to beneficiaries who are enrolled to an MTF?
RESPONSE: No"

a. Are you saying here that the requirements of 32 CFR 199.4 will not apply to MTF enrollees? If so, please state this explicitly and specifically. That is, please detail which provisions of 32 CFR 199.4 will or will not apply to MTF enrollees in respect to mental health/substance use disorder rehabilitation inpatient and partial hospitalization admissions, as well as Residential Treatment Center admissions.

RESPONSE: No, 32 CFR 199.4 does apply to MTF enrollees. The contractor will not review and approve mental health services; that is the responsibility of the MTF Commander. Once the MTF Commander has issued an authorization and/or referral, the contractor will comply with the MTF's determination.

b. If the requirements of 32 CFR 199.4 will apply to MTF enrollees, will the PCM (or MTF) be expected to conduct preadmission review for psychiatric inpatient, partial and residential care for these enrollees?

RESPONSE: Yes, the MTF PCM or a MTF specialist will determine the necessity for an admission.

c. If the PCM or MTF is expected to conduct preadmission review, what provisions will be made for such review outside the normal business hours of the MTF?

RESPONSE: The conduct of the review will be in the purview of the MTF staff and each MTF will determine what its internal procedures will be.

1217. C-7.5., paragraph 2, of the RFP states: "The contractor, using its authority as a Peer Review Organization, shall apply its own utilization management practices to inpatient care received by MTF enrollees in a civilian setting that extends beyond the initial diagnosis related groups (DRG) for which the MTF authorization was issued. The contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made."

a. How would this apply to mental health admissions, which are not reimbursed under the DRG methodology, but authorized on a per diem basis? At what point would the contractor be expected to initiate concurrent review for these admissions?

RESPONSE: Whether it is the DRG reimbursement methodology or the per diem reimbursement methodology, the contractor must apply its own utilization management practices when the diagnosis extends beyond the original initial diagnosis issued by the MTF staff.

b. Would the contractor's concurrent review determinations be subject to PCM or MTF Commander "override," or would a clinical denial by the contractor/PRO involving an MTF enrollee be subject to the ordinary reconsideration and appeals process?

RESPONSE: A denial by the contractor under the PRO authority involving an MTF enrollee would be subject to the reconsideration and appeals process of the TRICARE Operations Manual, Chapter 13.

1218. Questions 95 and 642 both reference the removal of provisions for 8 non-preauthorized mental health sessions from the TRICARE Operations Manual (August 1, 2002), which, it is indicated, will also be reflected in an amendment to the Policy Manual. The deleted paragraphs contained language permitting enrollees to self-refer to network mental health providers.

a. Does the Government's intention to eliminate the "unmanaged eight" provisions in an amendment to the Policy Manual correspond to a requirement for all enrollees to access outpatient mental health services (specialty care) through their PCMs, thereby eliminating the option of self-referral to the civilian provider network?

RESPONSE: By eliminating the mandatory option of self-referral for the first 8 mental health outpatient visits, the contractor is now allowed the freedom to propose in their own utilization management best practices to manage these services.

b. Specifically: Under T-Nex, will non-active-duty MTF enrollees (e.g., family members) be allowed to access civilian network mental health care without a PCM referral? Please note: the question relates not to the issue of medical necessity review, but to MTF Optimization. Put another way: if a non-active-duty MTF enrollee wishes to access outpatient mental health care, will the beneficiary be required to obtain the care at the MTF if the MTF has capability and capacity/availability? In that case, a PCM referral would be an indication that the MTF has determined that the needed services are not available through the direct-care system.

RESPONSE: Assuming that the contractor has not proposed (and the Government has accepted) to continue a number of initial unmanaged mental health visits, and for any non-active-duty MTF enrollee needing access to outpatient mental health care, the beneficiary will be required to obtain the care at the MTF if the MTF has capability and availability within the access standards. In addition, if the care is not available in the MTF, an MTF referral would be necessary and reported to the contractor for the care to be received in the civilian community without Point of Service being applied to the payment.

1219. Is the contractor permitted to offer incentives for providers to encourage electronic claims submission.

RESPONSE: Yes, Public Law 106-65, section 713(c), added a new section 1095c(c) that states: "The Secretary of Defense shall require that new contracts for managed

care support under the TRICARE program provide that the contractor be permitted to provide financial incentives to health care providers who file claims for payment electronically." These incentives, however, are not health care costs. Rather, incentives of this nature are an administrative cost which MCSCs can use to encourage providers to submit claims electronically. These "financial incentives" may be in the form of cash payments, the provision of software or hardware, payments to clearing houses on behalf of providers or any other incentive that rewards EMC submissions without reporting these costs as the cost of care. If an offeror elects to propose incentives, the dollars amount shall be included in the per member per month CLIN. The offeror may also elect to discuss incentive payments in their technical proposal.

1220. Your answers to questions #633 and #1104 appear to conflict. Do you agree?

RESPONSE: No. The two questions address two different issues: Question 633 asks will enrollees residing outside of the Government required Prime areas who have waived the access standards be allowed to continue their enrollment in Prime. Question 1104 asks where does the Government require Prime.

1221. Reference RFP Section Attachment L-8 Exhibit furnished with Amendment 4. The Non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries do not appear to be correctly stated.

a. MCSC RFP Attachment L-8 exhibit for non-TRICARE/Medicare dual eligible CHAMPUS beneficiaries shown for OP 2 West Contract is 1,542,822, South is 1,651,780, and North is 1,711,839. This count reflects a total of over 4.9 million non-TRICARE/Medicare dual eligible CHAMPUS beneficiaries.

b. The TDEFIC RFP Attachment L-5 shows the Grand Total of Dual Eligible as 1,679,884.

Please verify the correct count of non-TRICARE/Medicare dual eligible CHAMPUS beneficiaries used in Attachment L-8 of Amendment 4.

RESPONSE: Attachment L-8 is correct. TRICARE Dual Eligible beneficiaries will have their claims processed by the TDEFIC Contractor. Non-TRICARE Dual Eligible beneficiaries represent the population underwritten in the MCSC contract.

1222. Reference RFP Section L.14.f. Written Proposal Submission, subsection (1)(a) 7th sentence states, "Where the Government has specified performance standards (for example, the network access standards, claims processing cycle times, etc.) the submission of a proposal shall be deemed by the Government as the offeror's commitment to perform at, at least, the required standards."

a. Does this reference to "Where the Government has specified performance standards" pertain to standards in RFP Section H-8 Performance Guarantee?
b. Or, does this reference mean Section H-8 Performance Guarantee and all other related TRICARE documented standards as found RFP Section C-3?

RESPONSE: Section H represents performance guarantees, only. The performance standards are found in Section C of the RFP, the TRICARE Operation Manual, TRICARE Policy Manual, TRICARE Systems Manual, and 32 CFR 199.

1223. Reference RFP Section L.14.f. Written Proposal Submission, subsection (1)(a), Section H-8 Performance Guarantee, and Section M.6 Evaluation of Technical Approach - Please confirm and/or clarify each of the following regarding the submission of the Written Proposal Submission.

a. The Government has defined two broad sets of standards. The first set of standards is covered by RFP Section H-8 and requires the contractor to meet minimum standards that are covered by performance guarantees. The Government will consider offers that commit to higher performance standard(s), if the offeror clearly describes the added benefit to the Government. Any proposed change, i.e., commit to a higher performance standard than the RFP stated performance standard, must be included in the technical proposal. The Government has not committed to recognizing additional standards proposed under the performance guarantees, stating that, "We cannot evaluate proposal until such time as they are received; however, proposals will be evaluated in accordance with Section M".

RESPONSE: Please see our response to Question 1222. It is these standards that offerors may increase. Increasing performance guarantees goes to the issue of proposal risk. The Government, in considering an offeror's proposal will consider the Government's risk associated with the offeror's ability to deliver the services proposed, in the manner proposed, that fulfills the Government's requirements and objectives. The Government will consider performance guarantees in this light.

b. The second set of standards are those covered by RFP Section C-3. These standards are not covered by performance guarantees. Offerors can propose to exceed these standards. Any proposed change, i.e., commit to higher performance standard than the RFP stated performance standard, must be included in the technical proposal.

RESPONSE: Yes, if an offeror elects to commit to standards higher than those required by the Government, the higher standard must be included in the written technical proposal.

c. In addition, offerors may propose additional performance standards that will be accomplished to fulfill the requirements of the contract. Any additional standards must be included in the technical proposal.

RESPONSE: This is correct.

1224. Reference TOM 6010.51, Chapter 23, Section 1, Subsection 7.0 Network Development and 19.0 TRI
CARE SERVICE CENTERS. This subsection states, "The contractor shall operate TRICARE Service Centers (TSCs) at every MTF in the state of Alaska". The Data Tape lists the following DMIS ID and Facilities Names as Alaska MTFs.

DMIS ID	DMIS Facility Name
0005	Bassett ACH-FT Wainright
0006	3rd MED GRP-Elmendorf
0130	USGC Clinic Kodiak
0203	354th MED GRP-Elielson
0204	TMC FT. Richardson

0417	Ketchikan USCG Clinic
7044	USCG Clinic Juneau
7047	USCG Clinic Sitka

Is it the Governments intent to require the WEST Region contractor to establish TSCs at all the above MTF locations and place a provider representative at each site? Please clarify.

RESPONSE: Yes

1225. Reference Question 1055 and RFP Section H-8.j.
This question refers to the discrepancy between RFP Section H-8.j. and the TOM Chapter 1. Section 3.1.9.1. The Government stated the TOM requirements will apply and that the RFP Section H-8.j. would be updated. Amendment 0004 did not make all the necessary changes to be consistent with the TOM. The TOM has a four-tier performance standard and the RFP has a two-tier performance standard. Please advise which performance standard is correct.

RESPONSE: Section H-8 only applies performance guarantees to the last two time periods in listed in the manual. For these periods, the standards are consistent.

Response Revised 2 December 2002.
1226. Copy of question 1225 deleted 2 December 2002.

1227. Reference Questions 811 and 1131 and MAPS posted on the TMA website.
We request clarification regarding the Governments requirements of where TSCs must be located. If an offeror uses the supplied TMA maps of both inpatient/ outpatient and outpatient clinics, the offeror arrives at one answer. If a different offeror follows the question and answer to 131 which states, "Is it the Government's intent to require additional TSCs in areas now serviced by a single TSC" and the Government answered YES, this offeror will arrive at a different answer for the number of TSCs required.

Will the Government please clarify the TSC requirements under this contract? Also, we request that any clarification be made part of the RFP through a future amendment.

RESPONSE Revised 2 December 2002

RESPONSE: TRICARE Service Centers are required at each MTF, BRAC site, and contractor proposed Prime sites. We believe this answer is consistent with the response to questions 812 (811 does not address TSCs) and 1131 which state,

> "812. When reviewing the TSC information provided as part of the data tapes, it appears that the data provided reflects the operation in the current MCS contracts - not necessarily where TSCs are required under this solicitation. Would the government please provide a list of MTFs where an on-site customer service presence is required?
>
> **RESPONSE:** No. The requirement is that the contractor determine where to establish a customer service presence for all MHS eligible beneficiaries,

including traveling beneficiaries, at each MTF, Prime service area, and BRAC site, either within the MTF, on the base, or if a BRAC site, at a location convenient to beneficiaries. This is determinable from the zip code files. Please also refer to the response to Question 687 and 811."

"1131. Is it the Government's intent to require additional TSCs in areas now serviced by a single TSC?
NOTE: The bidder is not aware of any DoD dissatisfaction which would require TSC expansion and its related increase in administrative costs to the Government.

RESPONSE: Yes. The RFP states in Section C-7.16. that "The contractor shall establish a customer service presence for all MHS beneficiaries, including traveling beneficiaries, at each MTF, Prime Service area, and BRAC site…" In all instances, the Government's expressed requirement is for a TSC at each MTF which includes clinics.

1228. We appreciate it is the government's intent to ensure exceptional telephone service and deliver it with state-of-the-art call center technology. Multiple references and responses to questions have been provided; however, we remain unclear on a couple of key requirements. Typical call flow is captured in the following table. Following presentation of the table are questions concerning the government's desire to measure and receive accurate reports.

	Average Number of Seconds this Activity	**Average Cumulative Time**	**Activity**	**Standard Industry Definition**
1	12	12	Ring	Tone occurs in caller's ear to signal that the call is connecting, no answer has occurred yet.
2	15-30 (Average 22)	34	Automated Voice Response or Menu	Call is answered, caller hears an automated voice and is provided with multiple options designed to classify their call type and route appropriately. Often one or more of the options may include the provision of a fully automated service requiring their interaction. This tool is otherwise known as Interactive Voice Response (IVR) system.
3	2	36	Call Transfer	The process of moving the call out of the ARU into either the IVR or into a representative assisted queue.
4	Varied	NA	Interactive Voice Response	An automated application that permits the caller to complete their inquiry by interacting with technology. Current technology permits both voice and key pad for the caller's interaction.
5	20 (80 % in 20 Seconds)	56	Average Speed Answer (ASA)	The actual wait time or the time between when a caller has selected representative assistance while in the ARU, the call has been moved into the queue and actual wait time begins. Messages may occur

			during this wait. This metric is defined as the key measurement of Service Level. Workforce Management software supports staffing and scheduling according to a specific Service Level.
6		Representative Assistance	The point that a representative greets the caller
7	Varied	Hold	The point that a representative determines that additional/further assistance may be required and places the caller on hold to obtain and then relay. Automated messages may occur during this wait.
8	2	Call Transfer	The point that a representative determines that additional/further assistance is required by another person, dials the number and places the call into queue.
9	20 80 % in 20 Seconds	Average Speed Answer (ASA Queue 2)	The wait time in the second queue, also monitored as part of Service Level.
10		Representative Assistance	The point that a representative greets the caller
11	Varied	Hold	The point that a representative determines that additional/further assistance may be required and places the caller on hold to obtain and then relay. Automated messages may occur during this wait.

a. The responses to question 921 and to 1151 b. infer that a clock starts the moment a call enters the contractor's phone system, and that 95% of the calls destined to reach a representative should not exceed a total of 30 seconds. The table above captures a typical call flow with a service level designed to meet 80% of the calls within 20 seconds. Aggregating steps 1,2,3 and 5, the average number of seconds that will elapse from the ring time to the point a representative connects is 56 seconds. Software is available to measure each of the steps in call flow independently. But using an aggregate interpretation, we are having difficulty understanding how the standard could ever be achieved or measured. Have we understood the requirement correctly?

RESPONSE:

b. Please clarify if the step two definition above accurately captures the government's permissible design for ARU/menu design. Typically, in well-designed call menus, callers are asked to select the type of service desired, and if the service is available in an automated fashion, it is offered within the context of the menu. Section 3.4 of the TRICARE Operations Manual states that "95% of all telephones shall be answered within 2 rings by a Automated Response Unit (ARU)" and that "the caller shall have only two choices: transfer to an automated response or to an individual". Is it the intent to exclusively present a menu offering with automated or

rep assisted, or is it permissible to apply best practice and offer automated services within the context of the menu?

RESPONSE:

1229. The implied Option Period 1 count of at-risk eligibles as shown in Attachment L-8 of Exhibit 4 is about 4% lower than comparable counts for the first quarter of 2002 as obtained from DEERS data. The difference is comparable for NADD and ADD populations. Please explain the basis for amounts shown in Attachment L-8, including changes for periods beyond Option Period 1.

RESPONSE: Attachment L-8 reflects the Government's current estimates of the number of underwritten eligibles in each region. The OP 1 estimates further reflect the phased start dates for health care delivery by former region.

1230. Will the Government provide access by the Managed Care Support contractors to clinical, pharmacy, claims, encounter, eligibility, and cost data from the TRICARE Pharmacy Mail Order and TRICARE Retail Pharmacy contracts, the Pharmacy Data Transaction System, the TRICARE Dual Eligible Fiscal Intermediary contract, and each MTF?

RESPONSE: The Government will provide TRICARE program data in response to requests that establish a need to know in furtherance of contract performance by Managed Care Support (MCS) contractors in their medical management practices. Such data release will be subject to execution of data use agreements which will ensure use of the data in accordance with law, regulation, and policy and which will address the procedures, costs, etc., involved. The data will be supplied from the Government's own data bases to the MCS contractors, and not directly from the other contractors. The Government agrees to cooperate with the MCS contractors, in consultation with the other TRICARE contractors, post-award during the Transition Period to establish the minimum data the MCS contractor will require and to ensure protection of proprietary information of all contractors.

1231. Government responses have indicated that no printing will be required of the Managed Care Support Contractor (MCSC). Is the MCSC allowed to develop and print marketing and education materials? If the MCSC is allowed to develop materials, how does the approval process work? And, what position and TMA office/department will the MCSC work with to develop these materials? Please respond to specific statements about pertaining to the following scenarios:

Scenario 1. If the MCSC would like to produce a wellness brochure for some specific condition. The desired brochure is not produced by the Marketing and Education Contractor.

a. Is the MCSC allowed to design and produce this specific brochure for its own region?

RESPONSE:

b. Must the Government grant approval of the brochure design and content?

RESPONSE:

c. If approval is required, please describe the process the MCSC would follow to get approval and identify the approving office or agency.

RESPONSE:

Scenario 2. The MCSC wishes to design and produce a promotional giveaway that shows the TRICARE logo, the MCSC logo, and gives the toll-free beneficiary services telephone number for the MCSC's region.

d. Is the MCSC allowed to design and produce this item?

RESPONSE:

e. Must the Government approve of the design and authorize the production?

RESPONSE:

f. If approval is required, please describe the process the MCSC would follow to get approval and identify the approving office or agency.

RESPONSE:

1232. Given the total set of answers to questions regarding Prime areas and the requirement for TSCs, we wanted to validate that it is indeed the government's expectation that a physical TSC be located at each MTF (medical center, hospital, outpatient clinic), coast guard clinic, BRAC site, and other Prime Service Area within a region?

RESPONSE:

a. Also, please clarify if this also include the troop medical clinics and industrial health clinics, some of which are tied to active duty training activity, and some of which are only open for the weeks or months when this training activity occurs?

RESPONSE:

b. Does this include also satellite clinics?

RESPONSE:

c. Given that some of these clinics of each of these types sees fewer than 100 CHAMPUS patients in a year, is there a size threshold for this requirement?

RESPONSE:

1233. TSM, Chapter 3, Section 1.5, paragraph 1.2.3 states, "This application serves all TRICARE eligible beneficiaries." Will the MCSC be able to utilize the web application on behalf of the beneficiary?

RESPONSE:

1234. TSM, Chapter 3, Section 1.5, paragraph 1.2.3 states, "DEERS will send the MCSC or USFHP provider a Policy Notification, informing the MCSC or USFHP provider

that a pending enrollment exists for the beneficiary." What identifier(s) will be used for Policy Notifications of pending web transactions in order to distinguish them from other Policy Notifications? (Cross-reference TSM, Chapter 3, Section 1.4, paragraph 2.4, bullet 5).

RESPONSE:

1235. TSM, Chapter 3, Section 1.5, paragraph 1.2.3 states, "All reviews and acknowledgements shall be accomplished within four calendar days of receipt of the information. Additionally, within four calendar days of the submission, the MCSC or USFHP Provider shall contact the beneficiary to resolve discrepancies in the web-submitted application (if necessary). If the application is not accepted, the MCSC or USFHP provider shall send the beneficiary an explanatory letter within five calendar days." Will TMA consider changing the 'calendar' days to 'working' days? This change would be consistent with other enrollment performance standards. (Cross reference TOM, Chapter 6).

RESPONSE:

1236. TSM, Chapter 3, Section 1.5, paragraph 1.2.3 states, "DEERS will produce a daily report of all web-based pending enrollments that are greater than four calendar days old. Reports listing pending enrollments not processed will be distributed by DEERS to the Contracting Officers (COs) and Contracting Officers Representatives (CORs), Lead Agents and Managed Care Support Services (MCSS) MCSCs or USFHP providers."

a. We assume that the format and distribution will be mutually agreed upon during the Interface Meeting (within 30 calendar days following contract award). Please confirm.

RESPONSE:

b. Will TMA consider changing the 'calendar' days to 'working' days. This change would be consistent with other enrollment performance standards. (Cross reference TOM, Chapter 6).

RESPONSE:

1237. Reference TSM, Chapter 3, Section 1.5, paragraphs 1.2.5.2 and 1.2.6. The first referenced section states, "In all cases, upon acceptance of the PCM change, DEERS will send a Policy Notification to the MCSC and a PCM Change Letter to the beneficiary." The second reference states, "Upon disenrollment, DEERS will send a letter to the beneficiary informing the beneficiary of the change in or loss of coverage."

a. Will the address on the envelope for the PCM Change and the disenrollment letter reflect the MCSC address?

RESPONSE:

b. If so, will the MCSC be responsible for the processing (second mailing) of the undeliverable mail?

RESPONSE:

1238. TSM, Chapter 3, Addendum D - BUSINESS RULES: B. ENROLLMENT INTO HEALTH BENEFIT PROGRAM states, "Once policies are consolidated across contracts, a family cannot have multiple coverage policies of the same plan type during the same time period."
BUSINESS RULES: M. ENROLLMENT FEE PAYMENT TRANSACTION HISTORY REQUEST - 2. Person/Family Transaction Type Code states, "DEERS will default to 'F'." 3. Inquiry Person Type Code states, "Identifies whose ID is being submitted, sponsor or family member. DEERS defaults to sponsor."

The business rules do not appear to accommodate a former spouse enrollment in addition to the family enrollment. Please confirm how the former spouse policy and fee payments will be segregated from the family enrollment (cross-reference question 1000).

RESPONSE:

1239. TOM, Chapter 23, Section 1, paragraph 13.0 states, "The contractor is responsible for all enrollment activity in the state of Alaska in accordance with the provisions of Chapter 4." We assume the correct reference for enrollment activity should be Chapter 6. Please confirm.

RESPONSE: You are correct. The reference should be to Chapter 6.

1240. In Amendment 4, TMA Communications and Customer Service Directorate (C&CS) will now partner with the MCSC in developing and producing marketing and education materials. Given this, please also remove RFP references to the Marketing and Education Contractor in Section C, Item 7.1.12 and Section F.5, Item c(6) Collaborative agreement with marketing and education contractor to avoid confusion.

RESPONSE: This will be corrected in the next amendment.

1241. Can a TEDs record that has been PROVISIONALLY accepted be cancelled prior to clearing all relational and financial edits ?

RESPONSE:

1242. TEDs records generated as adjustments to claims processed under HCSR can be for either single suffix HCSRs or Multi-suffixed HCSRs. In those cases where a HCSR has been multi-suffixed, is it TMA's expectation that a single TEDs record for all suffixes be submitted or can multiple TEDs records be submitted, with one being generated for each corresponding HCSR suffix ?

RESPONSE:

1243. For this contract, will there be a transition deliverable requiring the transfer of the HCSR ICN, date/time stamp, number of lines and suffixes from the outgoing contractor? It appears that this data will be required for adjustments to claims previously processed by the outgoing contractor to uniquely identify each HCSR and the respective suffixes as generated for the original claim. Current contractor direction in the OPM and ADP allows for some flexibility in how certain services are

'rolled' together, this may present an issue to incoming contractors who are required to make adjustments to these previously processed claims.

RESPONSE:

1244. Is there a requirement to assign beneficiaries to Direct Care providers, MTF physicians, at the PCM by name level on the MCSC sub-contractors platforms? We understand beneficiaries have to be assigned to the Direct Care providers on the CHCS platforms for scheduling and appointments, but it is not clear as to whether that requirement carries forward to the contractors internal systems. Since the contractor should not be required to adjudicate claims for Direct Care services rendered at the military facilities, we assume that this requirement does not apply to the contractors internal system. Please advise.

RESPONSE:

1245. The TDEFIC Amendment 002 (Section C-1.1) includes the Northern Mariana Islands, Puerto Rico, Guam and the US Virgin Islands as part of the TDEFIC contract. However, MCSS RFP Section C-7.21.14 doesn't specifically exclude the Northern Mariana Islands In addition they are not excluded in RFP Section F.4.(b) of MCSS contract. Will claims for Medicare eligibles residing in the Northern Mariana Islands be excluded as part of the MCSS South contract (processed by the TDEFIC contract)? Please confirm.

RESPONSE:

1246. Please reference TOM Chapter 1, Section 3.1.3. This section states that the claims processing standards apply to both network and non-network claims *separately*. However, in Chapter 15, Section 4 of the TOM there is not a requirement for separate reporting of the claims processing timeliness or workload information. We assume that the statement in Chapter 1 of the TOM regarding separate application of standards applying to network and non-network claims is language that was intended to be removed under work simplification. Please confirm.

RESPONSE:

1247. In question #1219, the government indicated that contractors could pay providers an incentive for submitting claims electronically. However, in question #1058, the government indicated that the contractor could not pay a third party to convert provider claims to electronic claims since this cost would be passed on to the government. It is believed that providers will require a significant incentive to establish or convert their practice management systems to meet government requirements and that, given economies of scale that third parties can deliver for paper to electronic conversion, the difference in cost passed to the government through administrative fees (whether for incentives or paper claim conversion) will be comparable. This should be a competitive pricing decision by the contractor. Will the government reconsider it's position and allow the contractor to engage a third party to convert paper claims to electronic media? This will help solve one of the major obstacles to EMC which is the need to attach various explanatory documents to claims submissions which most practice management systems cannot handle.

RESPONSE:

1248. If the manuals (Policy, Operations, Systems, or Reimbursement) published with this RFP indicate a change, but with an implementation date on or after an undetermined date, should an offeror price this change, or will a Change Order be issued when the date is announced?

RESPONSE:

1249. C-7.25, as of Amendment 0006, requires the contractor to comply with the National Quality Forum document entitled, "Serious Reportable Events in Healthcare". The Government has incorporated the list of serious reportable events from the document into the Operations Manual, Chapter 7, Section 4. It is clear that the contractor must report on the serious reportable events from the NQF document. Does the contractor need to comply in any other way with the NQF document?

RESPONSE:

1250. C-7.11, as of Amendment 0006, states that the contractor shall reproduce enrollment and disenrollment forms, but the Operations Manual, Chapter 12, Section 1, 3.0., (as of change 5) states the Government will provide all enrollment materials. Please clarify who will be responsible for printing these materials.

RESPONSE:

1251. C-7.1.3., as of Amendment 0006, requires the contractor to offer TRICARE Prime and Extra in a 40-mile radius around military treatment facilities. In responses to a series of questions, the Government has clarified that all hospitals and clinics with a DMIS are military treatment facilities for the purposes of this requirement. We have the following questions about the hospitals and clinics listed on the most recent file at the DOD's official website for DMIS IDs, http://www.dmisid.com:

a. Must the contractor offer TRICARE Prime and Extra in a 40-mile radius around hospitals or clinics that ARE authorized TRICARE enrollment sites?

RESPONSE:

b. Must the contractor offer TRICARE Prime and Extra in a 40-mile radius around hospitals or clinics that ARE NOT authorized TRICARE enrollment sites?

RESPONSE:

1252. C-7.16., as of Amendment 0006, requires the contractor to establish a TRICARE Service Center at each MTF, Prime service area, and BRAC site. We have the following questions:

a. Some of the facilities listed as hospitals on the DMIS ID file are civilian facilities (e.g., Newport Hospital in Rhode Island, DMIS ID 5401, listed as an authorized TRICARE enrollment site). Must the contractor establish a TRICARE Service Center for these civilian facilities with DMIS IDs?

RESPONSE:

b. Some of the facilities listed as hospitals or clinics on the DMIS ID file are Uniformed Services Family Health Plan Designated Providers with a facility code of T.

Must the contractor establish a TRICARE Service Center for these USFHP providers with DMIS IDs?

RESPONSE:

c. The Government's response to question 1134.c. indicates that when a BRAC service area overlaps an MTF service area, the MTF TRICARE Service Center will fulfill the TSC requirement for both the MTF and the BRAC areas. When one or more MTF service areas overlap, can one MTF TRICARE Service Center fulfill the TSC requirement for more than one MTF?

RESPONSE:

d. Must the contractor establish a TRICARE Service Center at MTFs that are not authorized TRICARE enrollment sites, as shown at http://www.dmisid.com?

RESPONSE:

e. If the answer to c. is no and to d. is yes, then please confirm that the Government intends that, for example in the North Region, the contractor will establish separate TRICARE Service Centers for:

- the US Capitol Pharmacy
- the Soldiers Home in Washington, DC
- two Combat Support Hospitals at Walter Reed Army Medical Center
- 17 DMIS Table of Organization and Equipment (TOE) field, station, evacuation, combat support, and MASH hospitals spread throughout Maryland, Virginia, North Carolina, and Kentucky

RESPONSE:

f. The National Security Agency at FT Meade has a DMIS ID (5209), but is not classified as a hospital, clinic, or other facility type. Please advise whether the contractor should establish a TRICARE Service Center for this DMIS ID.

RESPONSE:

g. Some MTFs have satellite clinics on the same base. For example in the North Region, FT Drum has the Guthrie Army Health Clinic and a satellite, the Connor Troop Medical Clinic. A similar situation exists at Camp Lejeune, Marine Corps Base Quantico, and several other bases. Must the contractor establish a separate TRICARE Service Center for both Guthrie and Connor and for the various satellite clinics at Camp Lejeune and MCB Quantico?

RESPONSE:

h. The Government's response to question 1134.a. states that offerors must provide customer service on-site at the MTF. If the answer to h. is yes, will the Government provide space for a TRICARE Service Center at each MTF, including satellite clinics?

RESPONSE:

1253. Will the External Resource Sharing Program continue without disruption during the transition period and will it also be terminated as of the commencement

of health care delivery under the newly awarded contracts similar to the internal resource sharing agreements pending project evaluation?

RESPONSE:

1254. Will the MTFs have the ability to continue their existing direct contracts without disruption?

RESPONSE:

1255. With the permanent elimination of the existing Resource Support Program will the MTFs have the option to enter into direct contracts with the contractor when internal resource sharing is not financially viable for either the Government or the contractor?

RESPONSE:

1256. Does the incoming contractor have the option of retaining the existing internal resource sharing agreements pending the financial and reasonability assessment of the individual projects?

RESPONSE:

1257. What will be the time period for the services to determine if the transfer of funds from the former internal resource sharing (& resource support) agreements will be allocated to the affected MTFs?

RESPONSE:

1258. Will the contractor have the option to enter into internal resource sharing agreements with Veterans Affairs Medical Centers to provide care in the direct care system, enter into external resource sharing agreements at the VAMCs, or both?

RESPONSE:

1259. For the existing managed care support contracts, will the Government establish a date either before or after the new contract awards after which the current contractors will not be able to enter into any new internal resource sharing agreements or resource support projects?

RESPONSE: No

1260. The TMA response to question 1108 stated "… for foreign claims customer service, appeals, marketing, advertising, management or overhead not associated with the adjudicating claims must be in the PMPM, not the claim rate. The RFP doesn't appear to include any foreign member counts. Foreign claims processing is included in the TNEX South contract, but the estimated eligibles for the South contract have no relationship with foreign members. It seems illogical to extend foreign claims costs based on unrelated membership levels.

a. If TMA wants the costs not associated with adjudication to be priced in the PMPM price, what membership is to be used in pricing? What will be the source of the member counts? b. If member counts are to be used that differ from the estimated

South eligibles, how are they to be presented? The current Section B CLINS don't allow for different membership counts. c. As an alternative for foreign claims only, would TMA consider collapsing all costs associated with foreign claims processing back into the single per claim rate for pricing purposes?

RESPONSE:

1261. Section G,G-3a(3)(a)[1] states "Since all claims must be processed within 180 calendar days, the Government will not pay the outgoing contractor the healthcare or administrative cost associated with claims not processed to completion within 180 calendar days from the cessation of health care delivery." We assume this applies only to phase out of the upcomming T-Nex contracts. Also, current policy allows providers and facilities to submit claims up to one year after services are rendered, would the outgiong contractor be responsible for all health care costs from providers and facilities that submit claims for services during the contract period but after 180 days from cessation of health care delivery?

RESPONSE:

1262. C-7.1.3., as of Amendment 0006. When two MTFs are in the same ZIP code, does the Government consider this to be one Prime Service area or two unique but indistinguishable ZIP codes?

RESPONSE:

1263. C-7.16., as of Amendment 0006. When more than one MTF is in the same Prime Service Area, and none of the MTFs have space available for a TSC, can one off-base TSC serve these MTFs?

RESPONSE:

1264. C-7.16., as of Amendment 0006. The Government's revised response to question 1227, as of December 2, 2002, states that, "The Government's expressed requirement is for a TSC at each MTF which includes clinics." Please clarify if the requirement is:

a. A separate TSC at each MTF, and the definition of MTF includes hospitals and clinics, or
b. A single TSC for each MTF that includes satellite clinics on the same base as the MTF.

RESPONSE:

1265. L-14.d.(11), as of Amendment 0006, states that offerors will have one hour to respond to the initial set of questions, but L-14.d.(9), as of Amendment 0006, states the offeror will have two hours. Please confirm which is correct.

RESPONSE:

1266. L-16., as of Amendment 0006, requires offerors designated as large businesses to submit a subcontracting plan pursuant to FAR 52.219-9. This FAR clause requires the offeror to ensure that specified subcontractors also adopt a subcontracting plan. We have these questions:

a. Please confirm that the Government does not expect to receive subcontractors' subcontracting plans as a part of the offeror's initial submission.

RESPONSE: Confirmed. The required submission is a subcontracting plan from the prime.

b. Please confirm that the only L.16. requirements as far as subcontractors' plans are concerned is for the offeror to include the assurance that 52.219-9 II will be in all subcontracts, that subcontractors will submit their subcontracting plans to the offeror, that the offeror will monitor the subcontractors' compliance with the plan, and that the offeror will ensure that its subcontractors agree to submit SF294 and SF295.

RESPONSE: Confirmed

1267. M-9.c., as of Amendment 0006, states, "Results of this analysis will be used to assess the offeror's proposal risk". We have the following questions:

a. What elements of this analysis affect proposal risk?

RESPONSE:

b. Will higher evaluated cost represent additional risk? Will lower evaluated cost represent additional risk?

RESPONSE:

c. Will greater upward adjustments for realism represent additional risk?

RESPONSE:

d. Will greater downward adjustments for realism represent additional risk?

RESPONSE:

e. How does this proposal risk interact with the other elements of proposal risk in the technical proposal?

RESPONSE:

1268. M-9.c., as of Amendment 0006, states, "Results of this analysis . . . may be used by the Contracting Officer in making a responsibility determination." We have the following questions:

a. Please identify all standards and criterion, including any special standards specific to this procurement, that will be considered, evaluated, or both as part of the responsibility determination.

RESPONSE: Guidelines in determining responsibility are in the Federal Acquisition Regulation, Part 9.

b. How will the responsibility determination be weighted with other evaluation criteria?

RESPONSE: It is not weighted as it is not part of the source selection evaluation.

1269. Has contract MDA906-03-R-0001 been officially withdrawn?

RESPONSE:

1270. Amendment 4 reduced the year-to-year escalation factor for claims volumes, as follows:

	Prior to Amendment 4	Amendment 4
OP2 to OP3		
West	9.80%	8.09%
South	9.27%	7.10%
North	9.85%	7.79%
OP3 to OP4		
West	8.93%	7.48%
South	8.48%	6.63%
North	8.97%	7.23%
OP4 to OP5		
West	8.19%	6.96%
South	7.82%	6.22%
North	8.23%	6.74%

Would you please identify what factors played into the reductions of the claims escalation factors?

RESPONSE: The approach and factors used by the Government to calculate the claims escalation factors will not be released.

1271. Is the foreign claims process for the South Region contract subject to the Performance Guarantee standards outlined in Section H-8 of the RFP?

RESPONSE:

1272. Will the prime contractor be subject to performance guarantee withholds related to foreign claims for not meeting the section H-8 Performance Guarantee standards?

RESPONSE:

1273. Question 0648 pointed out that there are claims on the T-Nex data tapes for the South Region (and for the other Regions as well) which indicate a "contractor number" which differs from the contractor numbers which are to be expected within the various combined Regions, i.e., there are "contractor numbers" in the South Region claims data which are other than Contractor 3 or 6.
The government's response to Question 0648 was that other contractor claims were in the South (and other Regions) because the new T-Nex Regional assignments were based upon where the beneficiary lives not where they are enrolled.

Question 1114 followed-up on Question 0648 pointing out that current TRICARE policy determines contractor jurisdiction (and financial responsibility) based upon where a TRICARE prime beneficiary is enrolled not where they live, and asked if the government was making a change in TRICARE policy
The government responded that there was no change in TRICARE policy and that the contractor will be responsible for all care given to beneficiaries that reside in the Region.
For the South Region we have matched the non-foreign claims received on the data tapes which show a "contractor number" other than 3 or 6 (note that contractor number 3 on these tapes includes contractor 4) to the T-Nex enrollment file and an analysis of the enrollment DMIS codes indicates that many of these claims are for prime beneficiaries enrolled in Regions other than the South. In addition, we have reviewed the current Tricare Operations Manual, Chapter 8, Section 2, 1.0. and have found that Tricare Policy specifies that contractor jurisdiction is determined by the beneficiary's regional enrollment not by where they reside (this is why the claims were received by the government with "contractor numbers" other than the South region contractor numbers) . It would therefore appear that there are South Region claims in the North data, North claims in the South, etc.

Please advise if the government is making a change in Tricare policy related to contractor jurisdiction and financial responsibility for Prime beneficiaries which are enrolled in one Region but reside in another.

RESPONSE:

1274. OPM Chapter 1, Section 8, 4.5.4 indicated the outgoing and incoming contractors shall coordinate enrollment files no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming contractor's system. We are assuming the term "enrollment files" includes all other information relevant to enrollment, such as the cash collection/fee system, the PCM assignment history, etc. Is that a correct assumption?

RESPONSE:

1275. OPM, Chapter 6, Section 1, 3.3.1 indicates batch PCM reassignments will be accomplished based on parameters determined by the MTF including: DMIS, PCM ID, HCDP, Sex of beneficiary, Unit Identification Code, etc. Today neither the contractor's enrollment systems nor DEERS/NED contains the MTF PCM by name (PCMBN) information and MTF PCMBN identification. Additionally, the contractor's system does not contain the sponsor's UIC code and the UIC code contained on NED is not usually current for enrollment purposes. Because the PCMBN, MTF PCM ID, and UIC code are needed (in order to accommodate the OPM, Chapter 6, Section 1, 3.3.1 requirement) for all existing enrollees, is there a planned conversion between CHCS and DEERS to load the PCMBN information to DEERS prior to the file load being sent to the incoming contractor. If so, what is the timeframe in which this is to occur and who is responsible for resolving all of the conversion errors involved in the process? CHCS currently has restriction preventi
ng future PCMBN assignment, which means there will be thousands of beneficiaries that have not been assigned a PCMBN at the time of the file load from DMDC – how will these be resolved? Will all of these need to be reprocessed? Is there planned conversions between DEERS and the existing contractor's system in order to resolve discrepancies between data that exists today before the transition to the incoming contractor? If so, what is the timeframe in which this is to occur and who is

responsible for resolving all of the conversion errors? During the planned file load (OPM Chapter 1, Section 8, 2.6.1 states the incoming contractor shall obtain enrollment policy information from DEERS through an initial enrollment load file.), will the UIC code be given to the contractors at that time?

RESPONSE:

1276. The system's manual, Chapter 3, Section 1.5, 1.2.3 indicates DEERS will send the MCSC a policy notification of the actions performed by the beneficiary using the beneficiary self-service web feature. The language indicates the policy notification is in a "pended" status until the contractor performs an acknowledgement or a cancellation. At what point and how should this policy notification be loaded to the contractor's system? When is the pended enrollment sent to the CHCS system? Will the acknowledgement "trigger" another EIT to the contractor's system? At what point in this process is a new Prime enrollment card request generated?

RESPONSE: